IDENTIFICATION AND EMERGENCY INFORMATION CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST		SEX	TELEPHONE ( )
ADDRESS	NUMBER STREET	CITY		STATE	ZIP	BIRTHDATE
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PARENT / AUTHORIZED REPRESENTATIVE NAME	LAST	MIDDLE	FIRST			BUSINESS TELEPHONE ( )
HOME ADDRESS	NUMBER STREET	CITY		STATE	ZIP	HOME TELEPHONE ( )
PERSON RESPONSIBLE FOR CHILD	LAST	MIDDLE	FIRST	HOME TELEPHONE ( )		BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )
DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐ CALL EMERGENCY HOSPITAL ☐ OTHER EXPLAIN: _____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PERSON WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE PICKED UP

SIGNATURE OF PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	LAST DATE OF ENROLLMENT

FAMILY CHILD CARE HOME
NOTIFICATION OF PARENTS' RIGHTS

PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the family child care home without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the family child care home, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the family child care home without discrimination or retaliation against you or your child.
5. Be notified and receive, from the licensee, a written notice that lists the name of any person not allowed in the family child care home while children are present. ***(NOTE: This notice is only required when the Department has, in writing, excluded someone from the family child care home on or after January 1, 2001).***
6. Request in writing that a parent not be allowed to visit your child or take your child from the family child care home, provided you have shown a certified copy of a court order.
7. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: CCLD-Fresno Regional Child Care

   Licensing Office Address: 1310 E Shaw Ave Fresno, CA 93710

   Licensing Office Telephone #: 559-243-4588

8. Be informed by the licensee, upon request, of the name and type of association to the family child care home for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
9. Receive, from the licensee, the Caregiver Background Check Process form.
10. Be informed, by the licensee, that the facility has or does not have liability insurance (or a bond) that covers injury to clients due to the negligence of the licensee or employees of the facility.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE FAMILY CHILD CARE HOME TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

LIC 995A (8/08) (Detach Here - Give Upper Portion to Parents)

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of _____, have received a copy of the "FAMILY CHILD CARE HOME NOTIFICATION OF PARENTS' RIGHTS", the CAREGIVER BACKGROUND CHECK PROCESS and the FAMILY CHILD CARE CONSUMER AWARENESS INFORMATION form from the licensee. Little Learners Daycare
Name of Family Child Care Home

Signature (Parent/Authorized Representative) _____ Date _____

NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to the parent/authorized representative.

For the Department of Justice "Registered Sex Offender" database, go to www.meganslaw.ca.gov

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PARENT NOTIFICATION
ADDITIONAL CHILDREN IN CARE

As required by Health and Safety Code Sections 1597.44(c) and 1597.465(c), you are hereby notified that: *(Check one)*

☒ I am licensed as a Small Family Child Care Home and may provide care for more than six and up to eight children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than two infants are in care.

☐ I am licensed as a Large Family Child Care Home, and with an assistant provider, may provide care for more than 12 and up to 14 children when one child is enrolled in and attending kindergarten (including transitional kindergarten) or elementary school, and another child is at least six years old, and no more than three infants are in care.

196 Emerald Dr Merced CA 95340

(PRINT FACILITY ADDRESS)

(CUT ALONG DOTTED LINE)

RECEIPT OF PARENT NOTIFICATION (Facility Copy)
Additional Children in Care

I, _____, acknowledge receipt of the notification that this Small Family Child Care Home may be providing care for more than six and up to eight children, or that this Large Family Child Care Home may be providing care for more than 12 and up to 14 children in accordance with Health and Safety Code Sections 1597.44 and 1597.465.

_____ _____

(PARENT/AUTHORIZED REPRESENTATIVE SIGNATURE) (DATE)

_____

(CHILD'S NAME)

Maintain the completed and signed bottom half of this form in the child's record and provide the completed top half of this form to the child's parent or authorized representative.

LIC 9150 (8/14)

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

Little Learners Daycare
FACILITY NAME

TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____
NAME

. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE

PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE
( )

WORK PHONE
( )

AFFIDAVIT REGARDING LIABILITY INSURANCE FOR FAMILY CHILD CARE HOME

SECTION A:

I/We, the parent(s)/guardian(s) of _____,
(Child's Name)

acknowledge that Jeana and Taylor Martinez,
(Licensee's Name)

the licensee of Little Learners Daycare,
(Name of Family Child Care Home)

has informed me/us that this facility does not carry liability insurance or a bond in accordance with standards established by Family Child Care statute.

SECTION B: To be completed only if licensee does not own premises or the licensee is a member of a condominium or Homeowner's Association.

I/We, the parent(s)/guardian(s) of _____,
(Child's Name)

acknowledge that _____,
(Licensee's Name)

the licensee of _____.
(Name of Family Child Care Home)

has informed me/us that she/he does not own the premises or is a member of a condominium or Homeowner's Association, and the liability insurance, if any, of the owner/Homeowners' Association may not provide coverage for losses arising out of, or in connection with, the operation of the family child care home, except to the extent that the losses are caused by, or result from, an action or omission by the owner/Homeowners' Association, for which the owner/Homeowners' Association would otherwise be liable under the law.

_____ _____
Signature of Parent(s)/Guardian(s) Date

NOTE: The law requires Family Child Care providers to carry liability insurance or bond in the amount of $300,000 annually or to maintain this signed statement in the facility file. Lack of a bond or insurance does not effect the right of parents to bring legal action against the facility.

State of California—Health and Human Services Agency

California Department of Public Health

CALIFORNIA PRE-KINDERGARTEN AND SCHOOL IMMUNIZATION RECORD

CDPH

Pre-kindergarten facility and school staff must record the required vaccine dose information and status of requirements for each pupil. *See reverse side for guidance.*

PUPIL NAME (LAST, FIRST, MIDDLE)	STATEWIDE STUDENT IDENTIFIER (SSID)	ETHNICITY	RACE
		☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino	☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other _____
NAME OF PARENT/GUARDIAN (LAST, FIRST)	BIRTHDATE (MONTH/DAY/YEAR)	SEX	

REQUIRED VACCINE	DATE EACH DOSE WAS GIVEN (MM/DD/YY)					Permanent Medical Exemption	Notes for School Requirements
	1ST	2ND	3RD	4TH	5TH		
IPV / OPV (Polio)			Age:_____ years			☐	4 doses meet TK/K-12 requirement, as do: 3 doses, if ≥1 dose given at age ≥4 years.
DTaP / DTP – Age 0-6 years **Tdap / Td** – Age 7+ years (Diphtheria, Tetanus, Pertussis)			Age:_____ years	Age:_____ years		☐	5 doses meet TK/K-12 requirement, as do: 4 doses, if ≥1 dose given at age ≥4 years; 3 doses, if ≥1 Tdap dose at age ≥7 years; Tdap dose may meet 7th Grade requirement.
MMR (Measles, Mumps, Rubella)	Age:_____ months					☐	2 doses meet TK/K-12 requirement. Doses must be given at age ≥1 year.
Hib (*Haemophilus influenzae* type b)						☐	Required for pre-kindergarten only. At least 1 dose must be given at age ≥1 year.
Hep B (Hepatitis B)						☐	3 doses meet TK/K-12 requirement.
VAR / VZV (Varicella or Chickenpox)						☐	2 doses meet TK/K-12 requirement.
Tdap – 7th Grade (Tetanus, Diphtheria, Pertussis)	Age:_____ years					☐	1 dose given at age ≥7 years meets requirement for 7th grade advancement and 7th-12th grade admission.

STATUS OF REQUIREMENTS	Staff initials *I reviewed pupil's immunization record*	Has All Required Vaccine Doses	Requires Follow-up			Follow-up Date(s) (See conditional admission schedule or exemption end date)	Other *See codes on reverse side*	Date Requirements Met
			Temporary Medical Exemption	Missing Doses Not Currently Due—Conditional	Missing Doses Are Overdue—Needs Doses Now			
Pre-Kindergarten (Child care or preschool)		☐	☐	☐	☐		☐ IEP ☐ PBE (pre-2016)	
TK/K-12		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home ☐ PBE (pre-2016)	
7th Grade (Advancement or admission)		☐	☐	☐	☐		☐ IEP ☐ IND ☐ Home	

The California Department of Public Health places strict controls on the gathering and use of personally identifiable data. Personal information is not disclosed, made available, or otherwise used for purposes other than those specified at the time of collection, except with consent or as authorized by law or regulation. The Department's information management practices are consistent with the Information Practices Act (Civil Code Section 1798 et seq.), the Public Records Act (Government Code Section 6250 et seq.), Government Code Sections 11015.5 and 11019.9, and with other applicable laws pertaining to information privacy.

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____ (PRINT NAME OF AUTHORIZED REPRESENTATIVE), give my consent for Jeana and Taylor Martinez (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at Little Learners Daycare (PRINT NAME AND ADDRESS OF CHILD CARE FACILITY),

to administer inhaled medication to my child, _____ (PRINT NAME OF CHILD), and to contact my child's health care provider.

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE
ADDRESS OF AUTHORIZED REPRESENTATIVE	
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

INDIVIDUAL INFANT SLEEPING PLAN

Date of plan: _____

SECTION A: INFANT'S INFORMATION

Infant's Name	Gender	Birth Date

Authorized Representative's Name (Primary Contact)	Phone Number

Authorized Representative's Name (Secondary Contact)	Phone Number

SECTION B: SLEEPING ENVIRONMENT INFORMATION

At home, the infant sleeps in:

☐ Crib ☐ Play Yard ☐ Other (Specify) _____

What are the infant's usual sleeping hours?

_____ _____

_____ _____

What is the infant's average length of the infant's nap(s) during the day time?

_____ minutes _____ hours

Does the infant use a pacifier?

☐ Yes ☐ No ☐ Sometimes

If yes, brand: _____

SECTION C: INFANT'S ABILITY TO ROLL

My child, _____ is able to roll from their back to their stomach and stomach to their back beginning _____ / _____ / _____.

Authorized Representative Signature	Date

SECTION D: INFANT'S ABILITY TO ROLL IN CHILD CARE

Provider observed the infant is capable of rolling from their back to their stomach and stomach to their back.

Provider Signature	Date

Authorized Representative Signature (To be completed no later than the next business day following observation)	Date

SECTION E: MEDICAL EXEMPTION

Does the infant have a medical exemption? ☐ Yes ☐ No

If the infant has a medical exemption to sleep in a position other than on their back a licensed physician must provide instruction on an alternate sleeping position.

The following shall be included with the medical exemption:

- Instructions on how the infant shall be placed to sleep, including sleep position.
- Duration the exemption is to be in place
- The licensed physician's contact information
- Signature of the licensed physician and date of signature

ATTACH REQUIRED DOCUMENTS TO THIS FORM AND MAINTAIN IN THE INFANT'S FILE PURSUANT TO TITLE 22, SECTION 101429(a)(2)(c) FOR CHILD CARE CENTERS OR SECTION 102425(c)(2) FOR FAMILY CHILD CARE HOMES.

I certify that all information contained in this form is complete and accurate to the best of my ability.

Authorized Representative Signature	Date